BEFORE THE WEST VIRGINIA BOARD OF MEDICINE

IN RE: DINESH BABUBHAI SHAH, M.D.

CONSENT ORDER

The West Virginia Board of Medicine ("WV Board") and DINESH BABUBHAI SHAH, M.D. ("Dr. Shah") freely and voluntarily enter into the following Consent Order pursuant to the provisions of W. Va. Code § 30-3-14, et seq.

FINDINGS OF FACT

1. Dr. Shah currently holds a license to practice medicine and surgery in the State of West Virginia, License No. 12341, issued originally in 1980. Dr. Shah's address of record with the Board is in North East, Maryland.

2. On August 28, 2008, the State of Maryland Board of Physicians ("Maryland Board") finalized a Consent Order, wherein Dr. Shah was reprimanded and placed on three (3) years probation for failing to meet appropriate standards of medical care and failing to keep adequate medical records. (A copy of the August 28, 2008, Consent Order is attached hereto and incorporated by reference herein.)

3. On January 12, 2009, the WV Board's Complaint Committee initiated a Complaint against Dr. Shah based upon the aforementioned action taken by the Maryland Board.

4. By correspondence dated February 2, 2009, Dr. Shah responded to the Complaint initiated by the Complaint Committee.

5. Dr. Shah admits the above Findings of Fact and wishes to resolve this matter by entering into this Consent Order with the WV Board.

CONCLUSIONS OF LAW

1. The Board has a mandate pursuant to the West Virginia Medical Practice Act to protect the public interest. W. Va. Code § 30-3-1.

2. Probable cause exists to substantiate charges against Dr. Shah pursuant to W. Va. Code § 30-3-14(c)(17) and 11 CSR 1A 12.1(g), (u) and (x), all relating to having a license acted against and disciplined in another jurisdiction, failing to keep adequate written records, and failing to practice medicine acceptably with that level of care, skill and treatment recognized by a reasonable, prudent physician engaged in the same or similar specialty as being acceptable under similar conditions and circumstances.

3. The WV Board has determined that it is appropriate and in the public interest to place certain terms, conditions, and limitations on Dr. Shah's West Virginia medical license until he has fully and completely complied with the Consent Order he entered into with the Maryland Board.

CONSENT

DINESH BABUBHAI SHAH, M.D., by affixing his signature hereon, agrees solely and exclusively for purposes of this agreement and the entry of the Order provided for and stated herein, and the proceedings conducted in accordance with this Order, to the following:

1. Dr. Shah acknowledges that he is fully aware that, without his consent here given, no permanent legal action may be taken against him except after a hearing held in accordance with W. Va. Code § 30-3-14(h) and § 29A-5-1, et seq.

2. Dr. Shah further acknowledges that he has the following rights, among others: the right to a formal hearing before the Board, the right to reasonable notice of said hearing, the right to be represented by counsel at his own expense, and the right to cross-examine witnesses against him.

3. Dr. Shah waives all rights to such a hearing.

4. Dr. Shah consents to the entry of this Order relative to his practice of medicine and surgery in the State of West Virginia.

5. Dr. Shah understands that this Order is considered public information, and that matters contained herein may be reported, as required by law, to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank.

ORDER

WHEREFORE, on the basis of the foregoing Findings of Fact and Conclusions of Law of the Board, and on the basis of the consent of Dr. Shah, the West Virginia Board of Medicine hereby **ORDERS** as follows:

1. Effective immediately upon the entry of this Consent Order, and consistent with the Consent Order between Dr. Shah and the Maryland Board, the license of Dr. Shah to practice medicine and surgery in the State of West Virginia, License No. 12341, is hereby placed in a **PROBATIONARY STATUS,** for an indefinite period of time, not to exceed

a period of three (3) years, and continuing for the duration of his probation with the Maryland Board.

2. Dr. Shah's license shall remain in a **PROBATIONARY STATUS** until the Board receives written notification from the Maryland Board that all terms, conditions, and limitations placed upon his Maryland medical license have been fully and completely satisfied.

3. Dr. Shah is **PUBLICLY REPRIMANDED** for having his license to practice medicine and surgery acted against by the licensing authority in the State of Maryland.

4. Within ten (10) days of entry of this Consent Order, Dr. Shah shall provide a copy of this Consent Order to the Maryland Board by certified mail, return receipt requested. Further, Dr. Shah shall provide the WV Board with a copy of the return receipt as proof of notification to the Maryland Board.

5. In the event that Dr. Shah fails to meet any of the terms or provisions of this Order and/or the Consent Order he entered into with the Maryland Board, or if he otherwise violates any of the terms or provisions of said Order and/or Consent Order, his license to practice medicine and surgery in the State of West Virginia shall be **REVOKED**, effective immediately, without further process or hearing.

Entered this 27th day of May, 2009.

WEST VIRGINIA BOARD OF MEDICINE

John Wade

John A. Wade, Jr., M.D.
President

Catherine Slemp

Catherine Slemp, M.D., M.P.H.
Secretary

DINESH BABUBHAI SHAH, M.D.

Date: 5/11/2009

STATE OF Maryland

COUNTY OF Cecil, to wit:

I, Christina M. Hughes, a Notary Public for said county and state do hereby certify that DINESH BABUBHAI SHAH, M.D., whose name is signed above, has this day acknowledged the same before me.

Given under my hand this 11 day of May, 2009.

My commission expires Feb. 9, 2012.

Christina M. Hughes
Notary Public

CHRISTINA M. HUGHES
Notary Public
Cecil County
Maryland
My Commission Expires Feb 9, 2012

IN THE MATTER OF	*	**BEFORE THE**
DINESH B. SHAH, M.D.	*	**MARYLAND BOARD**
Respondent	*	**OF PHYSICIANS**
License Number: D23334	*	**Case Number: 2006-0252**

CONSENT ORDER

PROCEDURAL BACKGROUND

On April 24, 2008, the Maryland Board of Physicians (the "Board") charged Dinesh B. Shah, M.D. (the "Respondent") (D.O.B. 06/28/48), License Number D23334, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2005 Repl. Vol.).

Specifically, the Board charged the Respondent with violating the following provisions of the Act under H.O. § 14-404, which provide the following:

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; and/or
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review.

On July 2, 2008, a Case Resolution Conference was convened in this matter. Based on negotiations occurring as a result of this Case Resolution Conference, the Respondent agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board finds the following:

1. At all times relevant to the Board's charges, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on February 9, 1979, under License Number D23334.

2. The Respondent is Board-certified in Internal Medicine. The Respondent's practice address is as follows: 2327 Pulaski Highway, # 101A, North East, Maryland 21901.

3. The Board initiated an investigation of the Respondent after reviewing a complaint from a former patient (hereinafter, "Patient A")[1] who alleged that the Respondent, who was providing anti-coagulation therapy for her, was unaware that the dosage of anti-coagulation medication he had ordered for her was excessive, and failed to take appropriate corrective action after he was notified that he had ordered an excessive dosage of the medication.

4. Pursuant to its investigation, the Board referred this matter to the Delmarva Foundation ("Delmarva") for a review of the medical care the Respondent provided to Patient A. Delmarva conducted a review of this matter and submitted its findings to the Board in or about March 2007. This review concluded that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care and failed to keep adequate medical records with respect to Patient A. These findings are set forth *infra*.

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[1] To ensure confidentiality, patient names have not been used in this Consent Order. The Respondent is aware of the identities of all individuals referenced in this Consent Order.

Patient A

5. Patient A, then a 49-year-old woman, was diagnosed with atrial fibrillation in June 2005. Patient A had had an atrial septal defect repaired as a child but otherwise was without significant medical history. Patient A presented to the Emergency Department ("ED") at Perry Point Veterans Affairs Medical Center on June 25, 2005, with persistent palpitations after exercise and was found to be in atrial fibrillation. Patient A was sent to Harford Memorial Hospital where an electrocardiogram ("EKG") showed that a spontaneous conversion to sinus rhythm had occurred. Patient A was placed on aspirin and oral diltiazem, an anti-hypertensive medication, and was discharged. Patient A underwent monitoring with a 24-hour Holter monitor on July 7, 2005, which showed a normal sinus rhythm throughout.

6. On July 8, 2005, Patient A was evaluated by a cardiologist. Patient A underwent a second EKG, which revealed a normal sinus rhythm, and was scheduled for a nuclear stress test.

7. On September 12, 2005, Patient A underwent the nuclear stress test, at which time she went into atrial fibrillation early in the recovery period. The stress test was equivocal for anterolateral ischemia and showed an ejection fraction of 60%. Patient A's baseline INR (International Normalized Ratio) was measured as being 1.08. For her paroxysmal atrial fibrillation, the cardiologist placed Patient A on amiodarone, an antiarrhythmic agent; Coumadin (warfarin), an anticoagulant, at 5 mg; and maintained Patient A on diltiazem. Because the cardiologist was not going to be available, management of Patient A's anticoagulation was turned over to Patient A's primary care provider, the Respondent.

8. On September 16, 2005, Patient A presented to the Respondent for an office visit. Patient A's INR at that time was 1.31 (drawn on September 15, 2005). The Respondent advised Patient A to continue taking the daily 5 mg dosage of Coumadin and to have another INR test on September 19, 2005.

9. On September 19, 2005, Patient A had a repeat INR test done, which was measured as being 2.74.

10. On September 20, 2005, a staff person from the Respondent's office reportedly telephoned Patient A and told her to continue taking Coumadin, but to take two tablets for two weeks and then have her INR level drawn again. Patient A questioned this order, stating that her INR level was already in the therapeutic range (2.74). Patient A informed this staff person that because she was already taking 5 mg of Coumadin, increasing the dosage to two tablets would equal taking 10 mg of Coumadin per day. In response, the Respondent's staff person confirmed to Patient A that she should take two tablets per day for two weeks and then have a repeat INR drawn. The Respondent's chart for Patient A does not contain a dated note for this instruction. Instead, Patient A's chart contains an undated note at the bottom of a laboratory result sheet for September 20, 2008, stating, "Coumadin 2 tablets, repeat after 2 weeks."

11. Patient A complied with these instructions. On September 28, 2005, Patient A began to experience a variety of gastrointestinal complaints.

12. The next morning, on September 29, 2005, Patient A had a repeat INR taken, which was measured as being 13.4. At 8:33 a.m., Patient A faxed a copy of the laboratory result and a note stating her concerns to the Respondent's office. The

Respondent contacted Patient A by telephone that morning. According to an undated note in Patient A's chart, the Respondent documented that he "confirmed the dose of Coumadin to be 10 mg to my surprise." The Respondent advised Patient A to immediately discontinue taking the Coumadin and eat "foods that are rich in vitamin K." The Respondent noted that oral vitamin K would be an "alternative" but subjecting Patient A to INR determinations "at all kinds of off hours...does seem overly aggressive." The Respondent advised Patient A that she could go to the ED if she still had concerns about bleeding. The Respondent planned to recheck Patient A's INR on October 3, 2005.

13. Patient A continued to have gastrointestinal symptoms during the evening of September 29, 2005 and experienced gross hematuria in the morning of September 30, 2008. Patient A went to the ED at Harford Memorial Hospital where her INR was measured as being 11.15. Patient A was administered 10 mg of vitamin K subcutaneously and was admitted for reversal of anticoagulation with the infusion of four units of fresh frozen plasma. While hospitalized, Patient A's INR decreased to 1.65 and her hematuria ceased, at which point she was discharged on October 1, 2005, on 5 mg of Coumadin daily.

14. On October 12, 2005, the Respondent's office contacted Patient A to change an appointment she had previously scheduled for October 14, 2005. Patient A canceled her appointment.

15. At the Board's request, the Respondent submitted a letter, dated November 27, 2005, in response to Patient A's complaint. In his letter, the Respondent acknowledged that "lapses did occur in ... [Patient A's] ... care over a brief period of

about 7 days." The Respondent stated that in his experience, virtually all patients take Coumadin in the form of 1 mg or 2.5 mg tablets, and that when Patient A's September 19, 2005, INR was in the therapeutic range, he advised his office staff to convey to Patient A that "she should continue taking 2 pills, which would have been 2 mg (1 mg pill) or 5 mg (2.5 mg tabs)." The Respondent further stated, "[t]hus (unintentionally) as has been done perhaps thousands of time [sic], the 2 pills were continued with INR of 2.74 without realizing that she was taking 5 mg pills (a rarity for us)." (parentheticals in original).

16. The Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient A, in that he:

(a) failed to verify the precise dosage of Patient A's anticoagulation medication after assuming responsibility for her care;

(b) inappropriately relied upon the incorrect assumption that the dosage strength of the Coumadin tablets that was dispensed for Patient A was only 1 or 2.5 mg tablets, which resulted in inappropriate dosing of the anticoagulant medication he was prescribing for Patient A;

(c) failed to appropriately monitor the dosage of Patient A's anticoagulation medication after assuming responsibility for providing anticoagulation therapy for her;

(d) failed to appropriately monitor Patient A's anticoagulation status after assuming responsibility for providing anticoagulation therapy for her. The Respondent did not order that Patient A's INR levels be checked at an appropriate interval after he was informed that Patient A's INR level was 13.4 on September 29, 2005;

(e) failed to record adequate documentation in Patient A's medical chart with respect to the precise dosage of Patient A's anticoagulation medication he was prescribing. The Respondent did not record the milligram strength of anticoagulation medication he was prescribing in Patient A's chart, but merely recorded the dosage of medication in the form of pills prescribed;

(f) failed to recognize that Patient A's INR elevation on September 29, 2005 was such that she was at high risk for serious or life-threatening bleeding;

(g) failed to appropriately intervene in response to Patient A's elevated INR on September 29, 2005;

(h) failed to contact Patient A after September 29, 2005 having been placed on notice that Patient A had an elevated INR level; and

(i) inappropriately utilized non-medical and/or unqualified personnel to communicate with Patient A about dosing instructions on medications that have significant side effects and interactions.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent failed to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State, in violation of H.O. § 14-404(a)(22); and failed to keep adequate medical records as determined by appropriate peer review, in violation of H.O. § 14-404(a)(40).

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is this 28th day of August, 2008, by a quorum of the Board considering this case:

ORDERED that the Respondent's license to practice medicine in the State of Maryland shall be and hereby is **REPRIMANDED**; and be it further

ORDERED that the Respondent shall be placed on **PROBATION** for a minimum **PERIOD OF THREE (3) YEARS**, to commence on the date the Board executes this Consent Order, and until such time as the Respondent successfully completes the following terms and conditions:

1. Within six (6) months of the date the Board executes this Consent Order, the Respondent shall submit a written practice plan to the Board for management of anti-coagulation therapy.

2. Within twelve (12) months of the date the Board executes this Consent Order, the Respondent shall successfully complete, at his own expense, a Board-approved course of extensive duration in venous thromboembolic disease and anticoagulation. The Respondent shall enroll in this required course within six (6) months of the date the Board executes this Consent Order. The Respondent shall submit to the Board written documentation regarding the particular course he proposes to fulfill this condition. The Board reserves the right to require the Respondent to provide further information regarding the course he proposes, and further reserves the right to reject his proposed course and require submission of an alternative proposal. The Board will approve a course only if it deems the curriculum and the duration of the course adequate to fulfill the need. The Respondent shall be responsible for submitting written documentation to the Board of his successful completion of this course. The Respondent understands and agrees that he may not use this coursework to fulfill any requirements mandated for licensure renewal.

3. Within twelve (12) months of the date the Board executes this Consent Order, the Respondent shall successfully complete, at his own expense, a one-on-one tutorial in medical recordkeeping. The Respondent shall enroll in this required course within three (3) months of the date the Board executes this Consent Order. The Respondent shall submit to the Board written documentation regarding the particular course he proposes to fulfill this condition. The Board reserves the right to require the Respondent to provide further information regarding the course he proposes, and further reserves the right to reject his proposed course and require submission of an alternative proposal. The Board will approve a course only if it deems the curriculum

and the duration of the course adequate to fulfill the need. The Respondent shall be responsible for submitting written documentation to the Board of his successful completion of this course. The Respondent understands and agrees that he may not use this coursework to fulfill any requirements mandated for licensure renewal.

4. The Respondent shall practice according to the Maryland Medical Practice Act and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of medicine. Failure to do so shall constitute a violation of this Consent Order.

5. Within one (1) year of the date the Board executes this Consent Order, the Board will conduct a chart review and/or a peer review of the Respondent's medical care, at a time selected by the Board. Thereafter, the Board will conduct additional subsequent chart reviews and/or peer reviews at its discretion.

AND BE IT FURTHER ORDERED that after the conclusion of the entire **THREE (3) YEAR PERIOD OF PROBATION,** the Respondent may file a written petition for termination of his probationary status without further conditions or restrictions, but only if the Respondent has satisfactorily complied with all conditions of this Consent Order, including all terms and conditions of probation, and including the expiration of the **THREE (3) YEAR PERIOD OF PROBATION**, and if there are no pending complaints regarding the Respondent before the Board; and be it further

ORDERED that if the Respondent violates any of the terms or conditions of this Consent Order, the Board, after notice, opportunity for a hearing and determination of violation, may impose any other disciplinary sanctions it deems appropriate, including

but not limited to, revocation or suspension, said violation being proven by a preponderance of the evidence; and be it further

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and be it further

ORDERED that this Consent Order is considered a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. §§ 10-611 *et seq.* (2004 Repl. Vol.).

8/28/08
Date

C. Irving Pinder, Jr.
Executive Director
Maryland Board of Physicians

CONSENT

I, Dinesh B. Shah, M.D., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I admit to the Findings of Facts and Conclusions of Law, and I agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am

waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order after having had an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order, and understand its meaning and effect.

7/21/08
Date

Dinesh B. Shah, M.D.
Respondent

Read and approved:

8/1/08
Date

D. Lee Rutland, Esquire
Counsel for the Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF: Cecil

I HEREBY CERTIFY that on this 31st day of July, 2008, before me, a Notary Public of the State and County aforesaid, personally appeared Dinesh B. Shah, M.D., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public

My commission expires: 10/1/2010